COMMITTEE ON LEGISLATIVE RESEARCH
OVERSIGHT DIVISION

FISCAL NOTE

L.R. No.: 2136-03
Bill No.: HB 964
Subject: Childhood Lead Testing Program in the Department of Health.
Type: Original
Date: April 2, 2001

FISCAL SUMMARY

ESTIMATED NET EFFECT ON STATE FUNDS			
FUND AFFECTED	FY 2002	FY 2003	FY 2004
Insurance Dedicated Fund	$10,000	$0	$0
Childhood Lead Fund	Unknown	Unknown	Unknown
General Revenue	(Unknown to exceeding $1,870,920)	(Unknown to exceeding $2,193,895)	(Unknown to exceeding $2,253143)
Total Estimated Net Effect on All State Funds	**Unknown to exceeding ($1,880,920)**	**Unknown to exceeding ($2,193,895)**	**Unknown to exceeding ($2,253,143)**

ESTIMATED NET EFFECT ON FEDERAL FUNDS			
FUND AFFECTED	FY 2002	FY 2003	FY 2004
Total Estimated Net Effect on All Federal Funds*	**$0**	**$0**	**$0**

*** Revenues and expenditures unknown but exceeding $60,000 annually and net to $0.**

ESTIMATED NET EFFECT ON LOCAL FUNDS			
FUND AFFECTED	FY 2002	FY 2003	FY 2004
Local Government	**(Unknown exceeding $100,000)**	**(Unknown exceeding $100,000)**	**(Unknown exceeding $100,000)**

Numbers within parentheses: ( ) indicate costs or losses.
This fiscal note contains 14 pages.

FISCAL ANALYSIS

ASSUMPTION

Officials from the **Department of Conservation** and **Office of the State Treasurer** stated the proposed legislation would not appear to have a fiscal impact on the on their organizations.

Officials from the **Missouri Consolidated Health Care Plan (MCP)** stated this bill is similar to SB 572 of this session. This bill requires medical plans to offer coverage for testing pregnant women for lead poisoning and for all testing for lead poisoning authorized in Chapter 710. Testing for lead is done through testing blood specimens. This type of test is not costly. Therefore, this bill should have a minimal, if any, impact on the MCP.

Officials from the **Office of Secretary of State (SOS)** stated this bill establishes a Childhood Lead Testing Program and Fund in the Department of Health. The DOH will promulgate rules to implement this bill. Based on experience with other divisions, the rules, regulations and forms issued by the DOH could require as many as 14 pages in the *Code of State Regulations*. For any given rule, roughly half again as many pages are published in the *Missouri Register* as in the Code because cost statements, fiscal notes and the like are not repeated in the Code. These costs are estimated. The estimated cost of a page in the *Missouri Register* is $23.00. The estimated cost of a page in the *Code of State Regulations* is $27.00. The actual cost could be more or less than the numbers given. The impact of this legislation in future years is unknown and depends upon the frequency and length of rules filed, amended, rescinded or withdrawn. The SOS estimates the cost of the proposed legislation to be $861 [(14 pgs. x $27) + (21 pgs. x $23)] in FY 02.

Oversight assumes the SOS could absorb the costs of printing and distributing regulations related to this proposal. If multiple bills pass which require the printing and distribution of regulations at substantial costs, the SOS could request funding through the appropriation process. Any decisions to raise fees to defray costs would likely be made in subsequent fiscal years.

Officials from the **Department of Insurance (INS)** stated Health Insurers and HMOs will be required to amend policy forms in order to comply with the legislation. It is anticipated that current appropriations and staff will be able to absorb the work for implementation of this single proposal. However, if additional proposals are approved during the legislative session the INS will need to request additional staff to handle the increase in workload. The INS estimates 171 health insurers and 29 HMOs will be required to file amendments to their policy form to comply with legislation resulting in revenue of $10,000. If multiple proposals pass during the legislative session which require policy for amendments to be filed, the insurers will probably file one amendment for all required mandates. This would result in increased revenue of $10,000 for all.

Officials from the **Department of Public Safety - Missouri Highway Patrol (MHP)** stated the Department of Highway and Transportation would respond for the MHP on this proposal.

ASSUMPTION (continued)

Officials from the **Department of Highway and Transportation (DHT) - Division of Resource Management** stated this legislation requires health carriers to provide coverage for lead poisoning testing for pregnant women and children less than six years of age. This benefit must be covered at the same level of coverage as other covered benefits. The Department of Health in coordination with the Department of Social Services and Department of Elementary & Secondary Education is responsible for developing and providing questionnaires for every child to be assessed within six months of birth and annually until the child is six years of age to determine whether a child is at high risk for lead poisoning.

If the questionnaire indicates that a child is at high risk for lead poisoning the child shall be tested at least once every six months between the ages of six months and three years of age and then annually between the ages of three years and six years. In addition, any child to be considered at high risk and resides in housing currently undergoing renovations shall be tested at least once every three months during the renovation and once after the completion of the renovation. Children that are not at high risk for lead poisoning shall be tested once at the age of twelve months and once at two years of age. Any child not tested by the age of five years shall be tested at least once before the age of six years. The tests for lead poisoning shall consist of a blood sample that shall be sent to a state-licensed laboratory for analysis.

To determine the fiscal impact of providing the coverage for pregnant women, the DHT found that over the past three years the Medical Plan has had an average of 1,520 pregnancies per year and Westport Benefits, the DHT's third party administrator, provided the usual and customary rate (UCR) for the lead poisoning screening and specimen collection. The CPT codes the DHT used are 83645 for the screening and 36415 for the specimen collection. The average UCR, using the rates for Jefferson City and St. Louis, are $32 for the screening and $14 for the specimen collection. The DHT assumes that this test would be part of a woman's prenatal care and no office visit charge would be necessary. The DHT also assumes that the women have met their deductibles and maximum out of pocket benefits. Therefore, the total fiscal impact to the Medical Plan for the lead poisoning testing of pregnant women would be approximately $69,920 per year [1,520 pregnancies x ($32/screening + $14/specimen collection)].

To determine the fiscal impact of providing the coverage for children, the DHT had to determine how many of the children in DHT's plan would be at high risk for lead poisoning. The DOH provided information that they used in preparing their fiscal impact to this legislation. The DOH calculated this by five groups within the state. Those groups are St. Louis City, St. Louis County, Jackson County/Kansas City, Greene County/Springfield and Outstate (all other health jurisdictions). The DOH then designated a high risk factor based on population density, old housing, poverty and current elevated blood lead (EBL) to each of these groups. The risk factors

ASSUMPTION (continued)

for each group are: St. Louis City = 4, Jackson County/Kansas City = 2 and St. Louis County, Greene County/Springfield and Outstate = 1. The risk factors were then assigned a percentage rate where the percentage of total children in the group were determined as high risk. The risk factors are 5 = 100%, 4 = 80%, 3 = 60%, 2 = 40% and 1 = 20%. The DOH also used 1990 census data, adjusted for 1999, to determine the number of children in each group.

The census data from DOH showed 38,034 children in St. Louis, 84,088 in St. Louis County, 58,427 in Jackson County/Kansas City, 16,111 in Greene County/Springfield and 251,233 in Outstate. Therefore, the total population of children under the age of six was 447,893.

For purposes of this fiscal note, the DHT is going to use the percentage of children in each group to the total number of children statewide provide by the DOH to determine the demographics of the Medical Plan's children. Following are those percentages: St. Louis City = 8.5% (38,304/447,893), St. Louis County = 18.8% (84,088/447,893), Jackson County/Kansas City = 13% (58,427/447,893), Greene County/Springfield = 3.6% (16,111/447,893), and Outstate = 56.1% (251,233/447,893). Westport Benefits provided the current number of children in the Medical Plan. Currently the medical plan has 255 children under the age of 1; 259 under the age of 2; 276 under the age of 3; 268 under the age of 4; 258 under the age of 5; and, 260 under the age of 6. Based on this information, the following was determined:

Ages	# in STL City	# in STL Co.	# in Jack Co./K.C.	# in Greene/ Spgfld.	# in OS	Total
<1	22	48	33	9	143	**255**
<2	22	49	34	9	145	**259**
<3	23	52	36	10	155	**276**
<4	23	50	35	10	150	**268**
<5	22	49	34	8	145	**258**
<6	22	49	34	9	146	**260**
Total	**134**	**297**	**206**	**55**	**884**	**1576**

The number of children at high risk in each group is as follows:

Ages	# in STL City	# in STL Co.	# in Jack Co./KC	# in Greene/ Spgfld	# in OS	**Total**	# of Tests	**Total # of Tests**
<1	17	10	13	2	29	**71**	1	**71**
<2	18	10	13	2	29	**72**	2	**144**
<3	19	10	14	2	31	**76**	2	**152**
<4	18	10	14	2	30	**74**	1	**74**
<5	18	10	13	2	29	**72**	1	**72**
<6	18	10	14	2	29	**72**	1	**73**
Total	**108**	**60**	**81**	**12**	**177**	**438**		**586**

ASSUMPTION (continued)

The number of children not at high risk is as follows:

Ages	STL.City	# in STL Co.	# in Co./KC	# in Jack Spgfld	# in Greene/ # in OS	**Total**	1st Year	# of Tests 2nd Year	# of Tests 3rd Year	**Total # of Tests Yr 1 or 2**	**Total # of Tests Yr 3**
<1	5	38	20	7	114	**184**	1	1	1	**184**	**184**
<2	4	39	21	7	116	**187**	1	1	1	**187**	**187**
<3	4	42	22	8	124	**200**	1	1	0	**200**	**0**
<4	5	40	21	8	120	**194**	1	1	0	**194**	**0**
<5	4	39	21	6	116	**186**	1	1	0	**186**	**0**
<6	4	39	20	7	117	**187**	1	1	0	**187**	**0**
Total	**26**	**237**	**125**	**43**	**707**	**1,138**				**1,138**	**371**

The Department of Health also determined that 5% of children at high risk will be living in a home being renovated. The DHT assumed the renovation period would be one year. The legislation would require these children to be tested every three months during the renovation period. Depending on the age of the child at the time of the renovation they could have an additional two or three tests per child. Taking the average, the DHT assumes this will result in 2.5 additional tests. The number of children at high risk and living in a home being renovated is approximately 22 (438 x .05), resulting in an additional 55 (22 x 2.5) tests. The total number of tests that the Medical Plan would be responsible for covering the first or second year is approximately 1,779 (586+1,138+55) tests while the third and subsequent years will be approximately 1,012 (586+371+55).

The number of tests required for children that are not high risk for lead poisoning in this legislation differs from what was stated in SB 572. Although the number of tests decreases, it also has provisions for catching up those children that are between the ages of two and six years of age and were not tested previously. In the first two years, all children under the age of five in the first year, will be tested a total of two times over the two year period while children over five, but under six, will only be tested once in the two year period. Therefore, after the first two years, all of the children from the first year will have their testing complete.

Westport Benefits, our third party administrator, provided the DHT the UCR for the lead poisoning screening and specimen collection. The CPT codes DHT used are 83645 for the screening and 36415 for the specimen collection. The average UCR, using the rates for Jefferson City and St. Louis, are $32 for the screening and $14 for the specimen collection. The DHT also assumed that there would be an office visit charge. The average office visit charge is $62.50 per visit and the Medical Plan has a $15 co-pay on PPO office visits. Assuming that the children have met their deductible, maximum out of pocket benefit, and are using a PPO physician, the total fiscal impact to the Medical Plan for the lead poisoning testing of children under the age of six years would be approximately $166,337 per year [1,779 tests x ($32/screening + $14/specimen collection + $62.50/office visit - $15 co-pay)] for the first two years and $94,622 per year [1,012 tests x ($32/screening + $14/specimen collection + $62.50/office visit - $15 co-pay)] for all subsequent years.

ASSUMPTION (continued)

The total fiscal impact to the Highway & Patrol Medical Plan is approximately $236,257 for the first two years and $164,542 for all subsequent years. The DHT is responsible for 75% of the Medical Plan's participants and the Patrol is responsible for 25% of the participants. Based on this information, $177,193 of the cost in the first two years and $ 123,407 each subsequent year is due to the DHT participants and $59,064 of the costs in the first and second years and $41,135 each subsequent year is due to Patrol participants.

Historically, the DHT and the plan members have shared in any premium increases necessary because of increases in benefits. The costs may be shared in the long run (meaning shared between three categories: absorbed by the plan, state appropriated funds, and/or costs to individuals covered under the plan). However, the DHT Commission must make a decision on what portion they will provide. Until the Commission makes a decision, the DHT can only provide the cost to the medical plan.

Officials from the **Department of Health (DOH)** provided the following assumptions for **FN 2136-03/HB 964**:

A. Number of additional childhood lead tests that would be done annually based on the testing guidelines in the proposed legislation. No determination whether tests being run are capillary or venous.

Tests per child at normal risk:
9-12 mos = 1
13-24 mos = 1
25-36 mos = 0.5
37-48 mos = 0.5
49-60 mos = 1
61-72 mos = 0.5

Tests per child at high risk:
9-12 mos = 1
13-24 mos = 2
25-36 mos = 2
37-48 mos = 1
49-60 mos = 0.5
61-72 mos = 1

Additional Tests for homes being renovated: The DOH assumes 5% of total of high risk children living in homes being renovated. During 1 year increases tests by 2 = 5% of high risk kids children x 2:

ASSUMPTION (continued)

- Normal risk # based on one test of all children at 12 and 24 months, and 2 more tests of all children over 24 months assuming they were not tested earlier.
- High Risk # based on legislative proposal: 1 test (1 year), 2 tests (24 and 36 months), and 1 annual test (48 to 72 months).

- For purposes of the proposed legislation the determination of number of tests will use the following breakdown by tests per geographic region with the numbers of tests per area using the proposed testing frequency identified above.
- Calculated by 5 groups: St. Louis City, St. Louis County, Jackson County (includes Kansas City), Greene County (includes Springfield) and Outstate (all other health jurisdictions). Unable to separate statistics for Kansas City from Jackson County or Springfield from Greene County.
- Total figures for children six years of age or less are based on 1990 census data, adjusted for 1999. Total figures were divided in 6 equal 1-year age layers.

- The 5 groups were designated a "high risk factor" based on population density, old housing, poverty, and current EBL levels: St. Louis City = 4, Kansas City/Jackson County 2, St. Louis County, Springfield/Greene County and Outstate = 1. The high risk factor was given a percentage rate: 5 =100%, 4 = 80%, 3 = 60%, 2 = 40% and 1 = 20% and that percentage of total children in the group were determined as high risk or average risk.
- Using the number of tests per child for each "age layer" above, the number of tests per population group was determined and added together. A total of 330,026 tests annually would be expected to be performed.
- Currently approximately 80,000 tests are logged annually. This would increase the number of tests by 250,026 tests over what is performed currently.
- In the "real life" situation criteria to determine "high risk" might be as follows. Due to the difficulty of determining numbers based on the following criteria, the above assumptions were used.
  - Identification by geographical area would be overwhelmingly simple in certain areas of the state if only deteriorating lead based paint in older housing and poverty only were considered. However, due to the number of lead mining and smelter operations in the state, identification is more complicated.
  - Geographical area criteria based on % of pre-1950 housing, % of levels of 200 percent of poverty, Lead Superfund sites, Lead mining and smelter factories and current prevalence data might determine the following areas as high risk: St. Louis City, parts of Kansas City, parts of St. Louis County, Marion, Buchanan, Madison, St. Francois, Iron, Jasper, Newton Counties, almost all northern counties, many in the southwestern area and the Bootheel.
  - DOH currently reports childhood lead elevations by county to facilitate assignment of follow-up responsibility and tracking of the elevated cases. DOH has the capacity to use "census tract" to identify the highest percent of old housing and poverty, but it will be at

ASSUMPTION (continued)

least 2 years before DOH will have the capacity to "geo track" addresses of children by "census tract". An attempt has been made to identify "high risk" areas by Zip Code but they overlap county lines. Use of prevalence data to establish "high risk" areas statewide is limited due to low testing numbers in many areas of the state.

- Additional high risk criteria would be Medicaid eligibility and the determination of high risk by questionnaire as proposed in the legislation. These criteria pretty well overlap the areas mentioned under geographical criteria but distribution of them is difficult to determine at this time.

B. Determine number of additional data entry FTEs both for state and in Local Public Health Agencies:

- Currently DOH enters the data for approximately 1/3 of the 80,000 annual tests, i.e. 26,666 by approximately 1.2 FTEs. This translates into 22,222 per 1FTE.
- **The total increased test numbers and data entry need by regional groups:**

Area	Data Entry	Total Test #	FTE needed	Assume has	Need Additional
St. Louis City	self	49,698	2.2	1	1.2
St. Louis County	self	69,509	3.1	1	2.1
Springfield/Greene	self	13,318	0.6	0.5	0.1
KC/Jackson County	self KC only	57,649	2.6	1	1.6
Outstate	DOH	139,852	6.3	1.2	5.1
Total		**330,026**	**14.8**	**4.7**	**10.1**

- Therefore 250,026 additional tests per year would require approximately 10.1 additional FTEs 5.1 at DOH and 5.0 at the LPHAs.

C. Additional Assumptions

Personnel Needs:

- **Different than FN 1621-03N: 8 DOH Clerk Typist II** will be required for the increased data entry and follow-up of lead test results. DOH currently hires Clerk Typist II as data entry personnel and not Clerk I as previously indicated.
- **Different than FN 1621-03N: 1 Management Analyst Specialist II** will be required to search and apply for every federal and state lead grant that becomes available. Requirements for an FTE capable of searching and preparing grant applications for lead programs requires a person able to function at a higher level than an HPR II as previously indicated. Many of the grant programs require collaboration with local agencies.

ASSUMPTION (continued)

Other:

- There are currently 13,400 medical providers licensed to practice in the state of Missouri. Preparation and mailing of an **educational mailing** would cost approximately $10,000 based on the costs of the mailing of the testing guidelines in FY 2000.
- It is difficult to determine what the costs of conducting audits of provider records would be in order to **determine physician compliance**. An estimate is that we could contract with an agency to conduct a random sample audit for $20,000.

Assumptions: for FN 2136-03N HB 964 State Public Health Laboratory (SPHL)

A. Number of additional laboratory tests that would be done annually at the SPHL

. Routine screening would produce an increase of 316,256 tests statewide. Currently approximately 80,000 test are performed annually. This would increase the number of test by 236,256 over what is performed annually. Of the total new tests done annually (236,256) it is assumed the SPHL would perform approximately 1/3 of the total. This would be 77,965 tests. Follow up testing by the SPHL of those children found to have initial elevated lead level(11%) would add an additional 8,576 tests. Total increased testing for the SPHL is estimated to be 86,541. The SPHL would perform lead testing for those children who receive lead testing services from local health departments throughout the State. To determine this estimate, the immunization model for childhood immunizations was used. Approximately, 33% of childhood immunizations are performed in local health departments (city or county).

. It must be noted that the following assumption is based upon the SPHL not performing lead tests for private physicians. The total number of lead laboratory tests required with this legislation is much too large to be performed by a single laboratory. Thus, private laboratories would need to be utilized. Our projections are based on serving the non-Medicaid and uninsured population. (Medicaid population can go to a contract lab).

If sufficiently more tests were sent to the State Public Health Laboratory rather than private labs, a major capacity problem would be created in the lab, resulting in significantly higher costs to the DOH to implement this legislation.

B. Number and expense of adding additional laboratory staffing to perform 86,541 lead tests

. The SPHL presently performs approximately 14,000 lead tests annually. Based upon current staffing the following additional staff will be required. Due to laboratory space limitations, staffing needs are based upon routinely operating a 12 hour work day five days per week.

ASSUMPTION (continued)

		Total Annual
Laboratory Manager (Public Health Manager)	1 @ $44,448	$ 44,448
. Provide overall scientific management and supervision		
Sr. Public Health Lab. Scientist	3 @ $43,308	$129,924
. Provide scientific oversight, quality assurance verification		
Public Health Lab Scientist	6 @ $37,488	$224,928
. Perform laboratory analysis of blood samples for lead		
Medical Laboratory Technician	3 @ $23,184	$ 69,552
. Prepare samples for analysis		
Computer Info Technology Specialist	1@ $51,252	$ 52,252
. integrate testing data into data system for reporting and case management		
Clerk II	2 @ $19,764	$ 39,528
. Prepare testing kits for mailing to providers		
Clerk Typist II	3 @ $20,472	$ 61,416
. Perform data entry of client information and test results plus client billing		
Total New SPHL Staffing Expense		**$622,048**

C. Assumptions and cost of E&E required to perform additional SPHL testing

. Laboratory equipment leasing - lead testing requires specialized laboratory testing equipment. Based upon existing workload, five additional testing setups will be required. Each testing system can be leased for approximately $25,000 per year.

Total - 4 testing systems @ $25,000 ---- $100,000

. Laboratory reagents - the chemicals and other materials to perform a lead test cost approximately $3.00 per sample tested.

Total 86,541 samples @ $3.00 ----$ 259,623

. Blood collection kits - samples must be collected in special lead-free test tubes and packaged in unbreakable shipping containers. These collection kits cost $2 per kit.

Total 86,541 @ $2 ---$173,082

ASSUMPTION (continued)

. Transportation costs - The SPHL employs a statewide courier to pickup and deliver laboratory samples. This is much less expensive than using mail services because of Federal laboratory specimen mailing regulations. The increased cost to extend the statewide courier contract to all local health departments, will average $3 per sample collected.

Total samples 86,541 @$3 --$259,623

D. Assumptions regarding fees.

Authority currently exists for DOH to charge fees now for lead testing, but the department does not do so. It has been a struggle to get children tested for lead. Charging a fee will put up yet another barrier which will prevent children from being tested. The language is permissive regarding fees, not mandatory.

Oversight assumes that DOH would implement a fee to help cover the cost of the lead tests. The estimated revenue to the Childhood Lead Fund is unknown.

The DOH officials stated that based on the projected additional tests per year, it assumes the local public health agencies would require approximately 5 FTE (Clerk Typist IIs).

Officials from the **Department of Social Services - Division of Medial Services (DMS)** stated they assume there will be a fiscal impact. Currently, the DMS screens for lead poisoning through the EPSDT program. If a child has lead poisoning, the DMS continues to test until the poisoning is gone. The proposed legislation requires additional annual testing until the child reaches the age of six. Therefore, the fiscal impact is unknown, but greater than $100,000.

FISCAL IMPACT - State Government	FY 2002 (10 Mo.)	FY 2003	FY 2004
INSURANCE DEDICATED FUND			
Income - Department of Insurance			
Filing Fees	$10,000	$0	$0
NET ESTIMATED EFFECT ON INSURANCE DEDICATION FUND	**$10,000**	**$0**	**$0**
CHILDHOOD LEAD FUND			
Income - Department of Health			
Fees to Defray Testing Costs	Unknown	Unknown	Unknown
NET ESTIMATED EFFECT ON CHILDHOOD LEAD FUND	**Unknown**	**Unknown**	**Unknown**
GENERAL REVENUE			
Costs - Department of Health			
Personal Services (25 FTE)	($654,903)	($805,531)	($825,669)
Fringe Benefits	($218,279)	($268,483)	($275,195)
Equipment and Expenses	($957,738)	($1,079,881)	($1,112,279)
Total Costs - Department of Health	($1,830,920)	($2,153,895)	($2,213,143)
Costs - Department of Social Services - Division of Medical Services			
Medical Assistance Payments	(Unknown over $40,000)	(Unknown over $40,000)	(Unknown over $40,000)
NET ESTIMATED EFFECT ON GENERAL REVENUE FUND	**(Unknown over $1,870,920)**	**(Unknown over $2,193,895)**	**(Unknown over $2,253,143)**
FEDERAL FUNDS			
Income - Department of Social Services - Division of Medical Services			
Medical Assistance Payments	Unknown over $60,000	Unknown over $60,000	Unknown over $60,000
Costs - Department of Social Services - Division of Medical Services			
Medical Assistance Payments	(Unknown over $60,000)	(Unknown over $60,000)	(Unknown over $60,000)
NET ESTIMATED EFFECT ON FEDERAL FUNDS *	**$0**	**$0**	**$0**

*** Revenues and expenses unknown but exceeding $60,000 annually and net to $0.**

HW-C:LR:OD (12/00)

FISCAL IMPACT - Local Government	FY 2002 (10 Mo.)	FY 2003	FY 2004
PUBLIC HEALTH AGENCIES			
Personal Service Costs, Fringe Benefits, and Equipment and Expense	**(Unknown exceeding $100,000)**	**(Unknown exceeding $100,000)**	**(Unknown exceeding $100,000)**

FISCAL IMPACT - Small Business

Increased screening would potentially lead to the identification of more children with elevated blood lead levels, which could lead to the abatement of more lead hazards. This may increase business for small lead abatement contractors and possible also affect medical providers. Estimated fiscal impact is unknown.

DESCRIPTION

This act requires insurance companies to offer coverage for testing pregnant women and for children under the age of 6 for lead poisoning. This act requires the Director of the Department of Health to inform local boards of health when a case of lead poisoning is reported to the director. Health care professionals and health care organizations are required to report positive lead poisoning cases.

Beginning January 1, 2002, the Department of Health must implement a childhood lead testing program to test children under the age of 6 for lead poisoning. The test shall consist of a blood sample which must be sent to a state-licensed laboratory for analysis. Children less than six years of age who are not deemed high risk are to be tested once at the age of twelve months and once at two years of age. Any child that is not tested at twelve and twenty-four months of age shall be tested at least twice before the child's sixth birthday and any child at least five years of age but less than six who has not been tested, shall be tested once before the child's sixth birthday.

The Department of Health shall identify geographic areas in the state that are at high risk for lead poisoning. All children six months of age through six years who reside or spend more than 10 hours a week in an area identified as high risk shall be tested annually for lead poisoning. Any child who tests positive for lead poisoning shall receive follow-up testing, in accordance with guidelines and criteria established by the American Academy of Pediatrics, at the priority intervals and using the methods specified in such guidelines.

The Department of Health, in coordination with the Department of Social Services and the Department of Elementary and Secondary Education, shall develop and provide questionnaires for every child not identified as high risk to be assessed within six months of birth and at least once a year thereafter until the child is six years of age. The questionnaire shall follow the recommendations of the Centers for Disease Control and Prevention.

DESCRIPTION (continued)

The Department of Health is to promulgate rules to identify pregnant women who may be at high risk for exposure to lead poisoning. The Department of Health is required to develop an educational mailing list to be sent to physicians informing them of the childhood lead testing program.

The Department of Health is required to convene a task force to investigate the imposition of a fee on manufacturers of products containing lead. Fees collected from such manufacturers shall be deposited in the Childhood Lead Testing Fund.

Beginning January 1, 2003, and every year thereafter, the Department of Health is required to submit a report evaluating physician compliance with the act to the General Assembly.

The act requires child care facilities to require a child's parent to provide evidence of lead poisoning testing. If the parent fails to submit evidence of lead poisoning testing, the facility is required to inform the parent of the issue and where the parent can obtain testing for the child.

This act creates the Childhood Lead Fund. The fund is to be used to fund the administration of the childhood lead programs.

This legislation is not federally mandated and would not duplicate any other program.

SOURCES OF INFORMATION

Department of Health
Missouri Consolidated Health Care Plan
Department of Conservation
Office of the Secretary of State
Office of the State Treasurer
Department of Social Services
Department of Insurance
Department of Highway and Transportation
Missouri Highway Patrol

Jeanne Jarrett, CPA
Director

April 2, 2001

HW-C:LR:OD (12/00)